Fundamentals of Executive Leadership: A Textbook for Scholar-Practitioners Workbook

M.S. in Healthcare Administration and Medical School Leadership

This is the thematic context for the 1st edition textbook by T.J. Greer, MD-PhD

Harvard University
Emory University
Johns Hopkins

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Fundamentals of Executive Leadership: A Textbook for Scholar-Practitioners Workbook

M.S. in Healthcare Administration and Medical School Leadership

The objective of this workbook is to tailor *Fundamentals of Executive Leadership: A Textbook for Scholar-Practitioners* to medical school leaders and hospital administrators. Review all of these excerpts, results, and attached articles. Then, answer all of the essay questions. Completing these essays constitute an entire M.S. in Healthcare Administration and Medical School Leadership. Finally, return to answer these introductory questions.

1. *Are medical students clear about their roles on rotations?*

2. *Are medical students positively or negatively impacting patient outcomes?*

3. *What roles do medical school administrators play in clarifying roles and reducing negative patient outcomes that are the results of medical school students on rotations?*

J E Chapman, Reflections on the medical deanship, *Academic Medicine*, Volume 73, Issue 6, June 1998, Pages 654–656

In 35 years, being dean of a medical school has changed dramatically. Thirty years ago, the dean's world was still the medical school and its affiliated hospitals, but soon this world was transformed by **new emphasis on research (and the resources to conduct it)** and the increase of specialty medicine. The medical school became larger and the affiliated hospital more complex. They consolidated into the modern academic medical center, which then became more diverse and self-contained and eventually became an island of special expertise and achievement in medicine, the biomedical sciences, and clinical care. Fifteen years ago, the academic medical center began to be transformed again, this time by its competition with or incorporation into managed care and other health care delivery systems. The medical school dean now operates in an environment far different from that of the 1960s. **Deans spend 90% of their time on five major issues: too few resources, isolation and division of activity within the institution, poor management, excessive traditionalism, and too few people with too much to do.** In addressing these issues, the dean has several powerful levers, including the appointment and promotion of faculty, appointments to committees and task forces, assignments of budget and space, and controlling the agenda and leading the debate in the institution. Another but less tangible issue is the dean's attitude. Another but less tangible issue is the dean's attitude, which has enormous impact on what happens at the medical school and in its programs. The deanship will continue but in the new context of a health care delivery system-with variations on the same five problems and with the same ten levers available to address them. The responsibility is old; only the context is new.

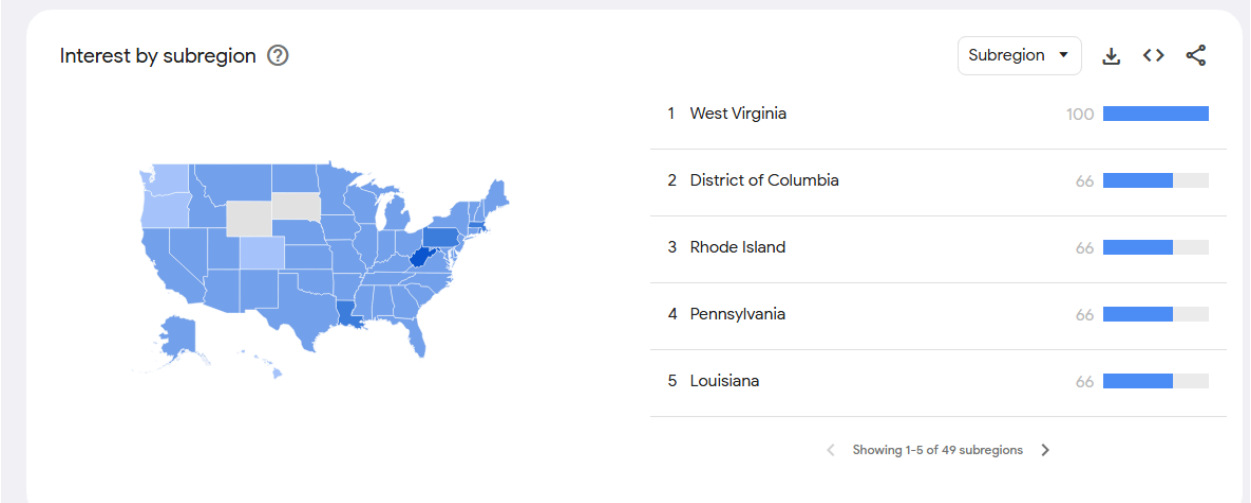
One Long Day in the Life of Dean Ted DeWeese | Johns Hopkins Medicine

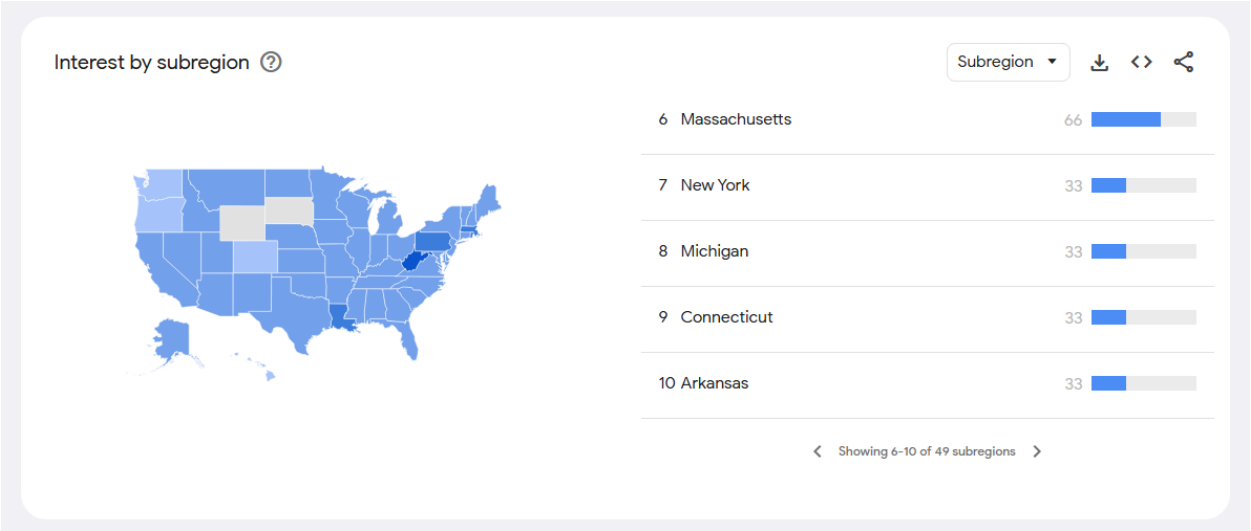
This article provides a very organic snapshot of the life of a medical school administrator.

Hromas, R., Leverence, R., Mramba, L. K., Jameson, J. L., Lerman, C., Schwenk, T. L., Zimmermann, E. M., & Good, M. L. (2018). What a medical school chair wants from the dean. *Journal of healthcare leadership*, *10*, 33–44.

Like the evolution of the dean position, the requirements of the medical school chair position are often distinct from what led to the chairs' success in academic medicine. The current academic medical center chair has to balance educational needs and research endeavors with the business of their specialty, such as enhancing clinical revenue and decreasing clinical expenditures, recruiting and managing an increasingly diverse workforce, and personally dealing with patient satisfaction issues. The role of chair is evolving so rapidly that academic health leaders disagree on the skills needed for a successful chair, with deans placing more emphasis on educating trainees, mentoring faculty, and supporting research, while hospital CEOs place more value on the quality and volume of patient care. **The growing administrative and financial responsibilities have led some chairs to delegate responsibility of education, research, or faculty development to others in the department.** Indeed, many top candidates for chair positions increasingly prefer to seek leadership of centers or institutes in order to maintain more of a traditional academic mission.

"medical school rotations" (2004- Present)





"The Charleston Campus of the WVU Health Sciences Center was formed in 1972 as part of a federal rural health initiative to expand medical schools beyond the traditional campus, making it one of the oldest regional medical education campuses in the Nation. An affiliation with the

newly formed Charleston Area Medical Center (CAMC) to direct CAMC residency programs was also established that year".

"The WVU School of Medicine Charleston Campus will demonstrate its core values (excellence, integrity, compassion, dedication, respect, empathy, personal and social responsibility) in carrying out its mission and goals.

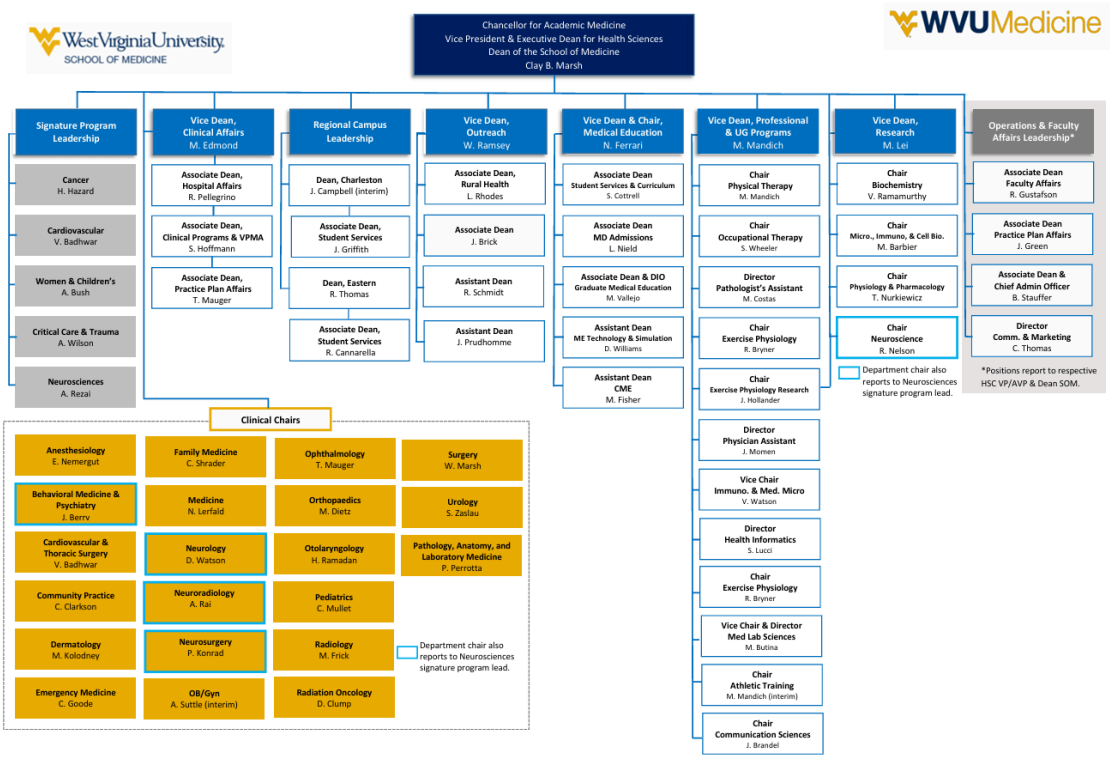
"The WVU School of Medicine-Charleston's mission goals are medical discipline dictated but should include.

• Education: provide the information and experience to achieve an adult learning life-time process to assure the core competencies necessary for the practice of medicine.

• Patient Care: provide a level of quality care that assures a compassionate patient centered approach based on practice-based learning and improvement in an environment that values ethical principles and sensitivities.

• Research: provide an academic environment that values innovation, challenges, transparency and investigation that is subject to the scrutiny of peers and the public.

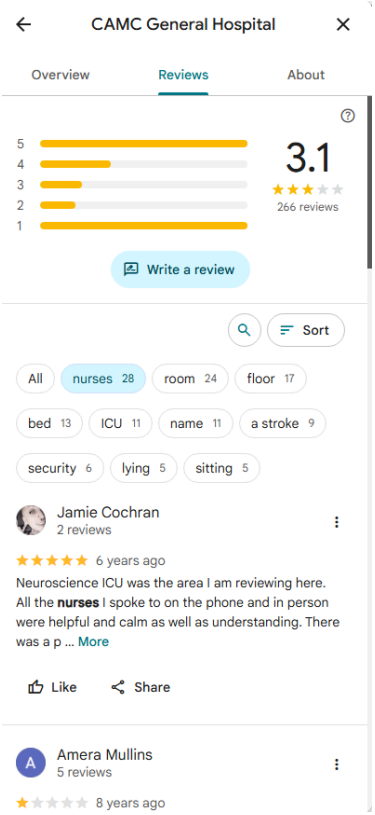
• Service to the State: provide an environment that values, nurtures and facilitates the involvement of faculty, residents and students in "community" participation whether medical or not" (West Virginia University, 2026).

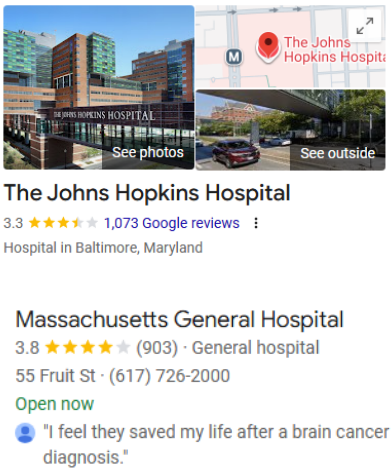


(ZOOM TO VIEW)

Charleston Area Medical Center (Vandalia Health)

"CAMC was formed Jan. 1, 1972, with the merger of the two dominant hospitals in the city: Charleston General Hospital and Charleston Memorial Hospital. The institutions merged to create a community-based academic medical center capable of training future physicians (CAMC, 2026). "Kanawha Valley Hospital joined CAMC in 1986 and was renamed Women and Children's Hospital two years later upon completion of a major expansion project" (CAMC, 2026). "Then in 2006, CAMC purchased Putnam General Hospital and renamed it Teays Valley Hospital, becoming the medical center's first hospital located outside of Charleston. On Jan. 1, 2023, Greenbrier Valley Medical Center in Ronceverte, West Virginia, became part of CAMC and on April 1, 2023, CAMC's purchase of Plateau Medical Center in Oak Hill, West Virginia was finalized" (CAMC, 2026).





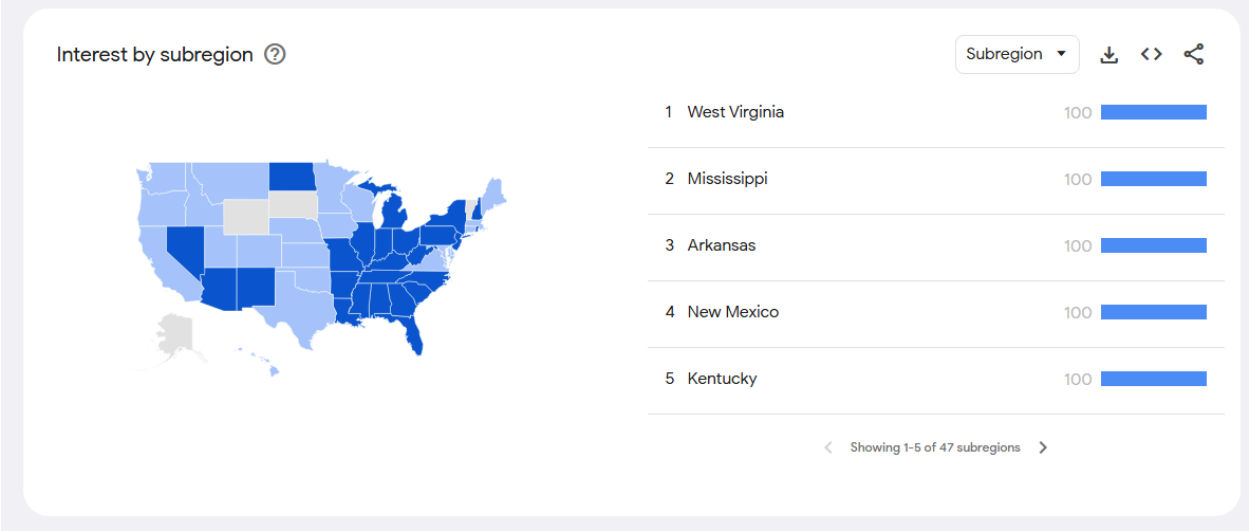
VANDALIA HEALTH, INC. AND SUBSIDIARIES

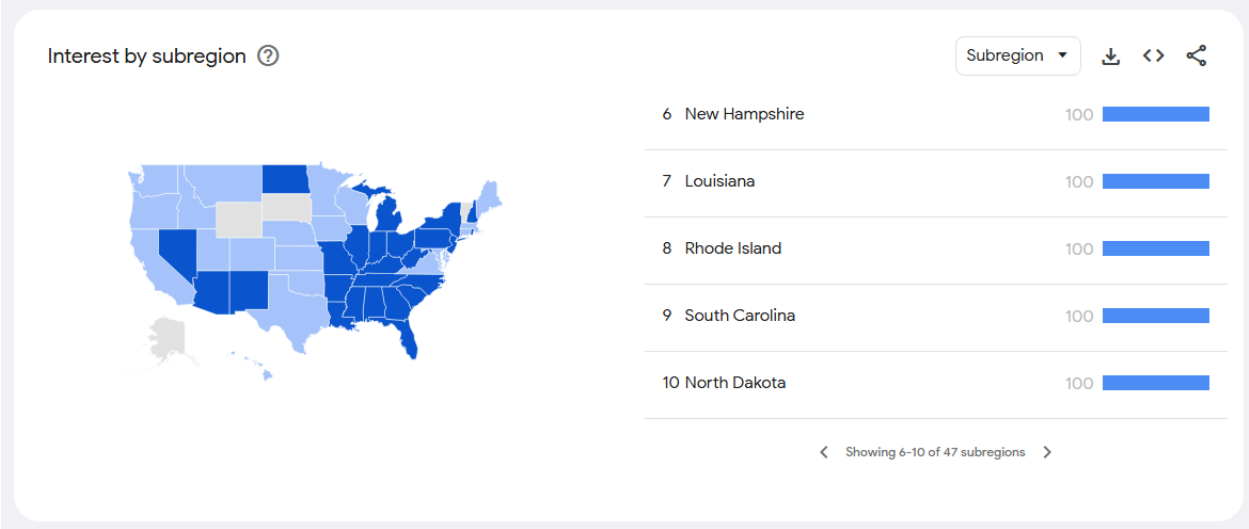
CONSOLIDATED BALANCE SHEETS
AS OF DECEMBER 31, 2024 AND 2023
(In thousands)

	2024	2023
ASSETS		
CURRENT ASSETS:		
Cash and cash equivalents	$ 95,559	$ 66,150
Short-term investments	59,701	175,424
Current portion of assets limited as to use	19,760	29,103
Patient receivables—net	648,308	465,429
Other receivables—net	45,872	39,077
Estimated amounts due from third-party payors	91,616	68,505
Inventories	51,822	42,166
Prepaid expenses and other	37,082	37,596
Total current assets	1,049,720	923,450
ASSETS LIMITED AS TO USE	656,914	636,155
PROPERTY, EQUIPMENT, AND INFORMATION SYSTEMS—Net	879,222	832,729
RIGHT OF USE ASSETS—Operating leases	52,676	55,406
OTHER ASSETS:		
Goodwill	124,086	115,963
Other	32,323	43,256
Total other assets	156,409	159,219
TOTAL	$ 2,794,941	$ 2,606,959

(Continued)

"How to sue a hospital?"





Related topics | Rising

1	Medicine - Topic	Breakout
2	Negligence - Topic	Breakout
3	Medical malpractice - Topic	Breakout
4	Malpractice - Topic	Breakout
5	Law - Topic	Breakout

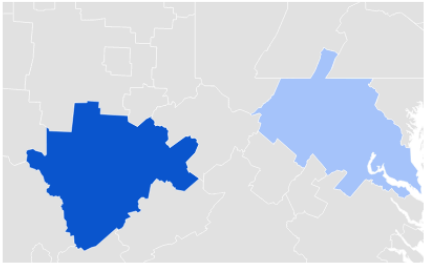
Showing 1-5 of 23 topics

Related queries | Rising

1	negligence	Breakout
2	hospital negligence	Breakout
3	how to sue a hospital for negligence	Breakout
4	lawyer to sue hospital	Breakout
5	how to sue a doctor	Breakout

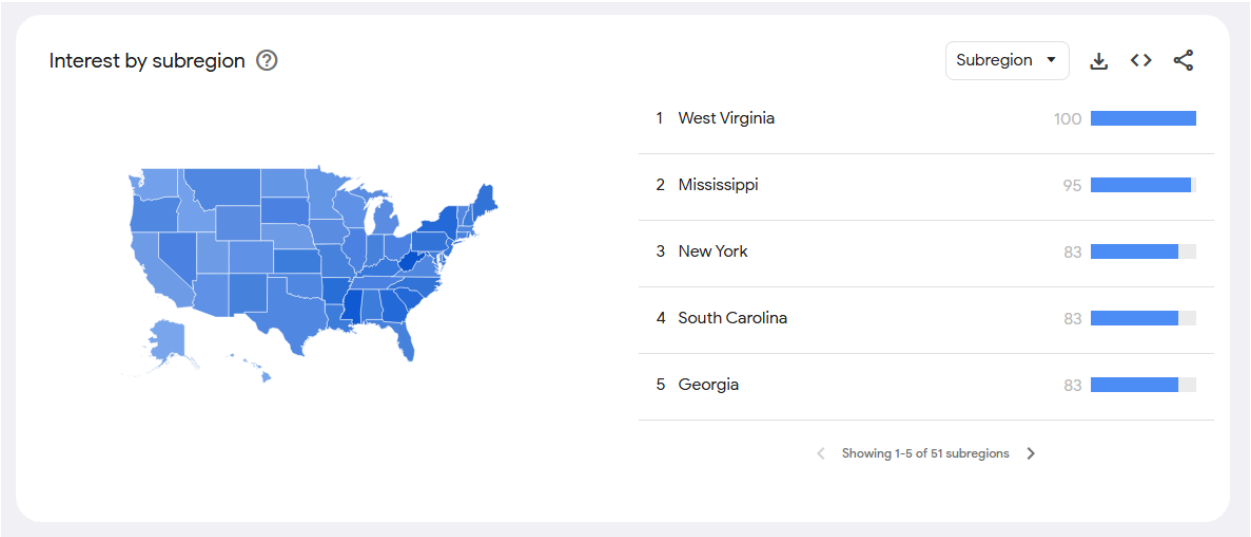
Showing 1-5 of 10 queries

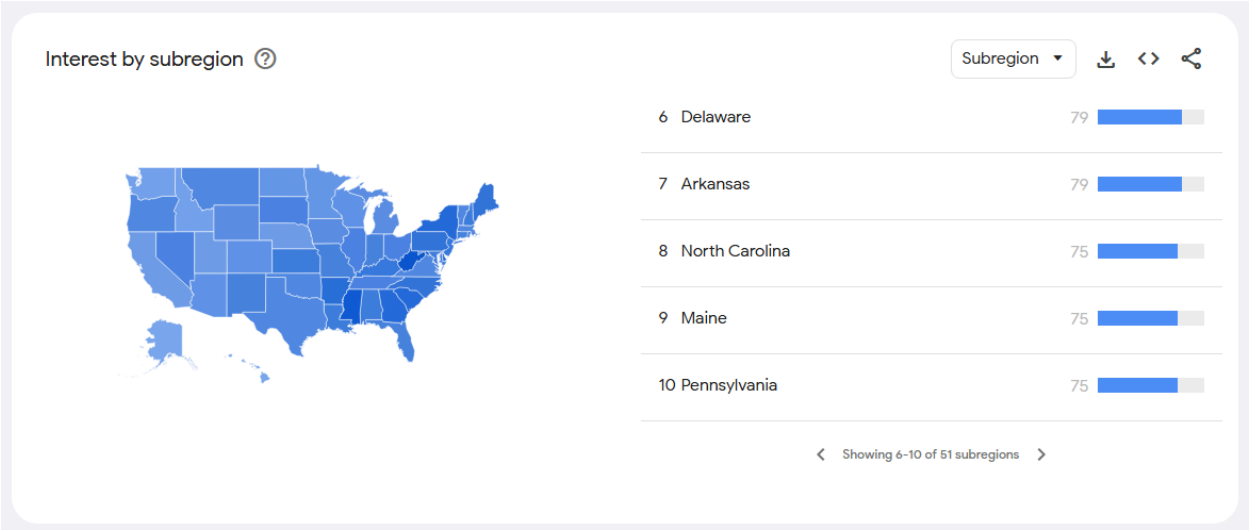
Interest by metro | Metro



1	Charleston-Huntington WV	100
2	Washington DC (Hagerstown MD)	<1

"medical malpractice lawyers"





"In 2017, the overall West Virginia medical malpractice pure direct loss experience increased from 80.7% in 2016 to 90.5%. The average West Virginia pure direct loss ratio for calendar years 2008 through 2017 is 41.0% with the lowest ratio of 1.5% occurring in 2008 and the highest ratio of 90.5% occurring in 2017. This report will address the volatility of the West Virginia medical malpractice market as well as the increased loss ratios realized in the most recent years" West Virginia Offices of the Insurance Commissioner, 2018). This far outpaces nationwide loss ratios and confounding experts (Angotti & Straface Attorneys at Law, 2026)".

Malpractice Data Source (2024)
List: States with highest medical malpractice cases

Medical Student Enrollment (2023)
States with the most students enrolled in medical school - Becker's ASC

Mortality Rates (2019 - 2023)
Mortality Table for US by State | HDPulse Data Portal

R= - .46
States with more medical students tend to have lower malpractice suits.

R= - .42
States with more medical students tend to have lower mortality rates in general.

Wile, R. K., Barnes, K. E., Charondo, L. B., Breyer, K., Lager, J., Campbell, A., & O'Sullivan, P. S. (2024). Student challenges during third‐year perioperative clerkships through the lens of faculty and residents: a qualitative study. *The Clinical Teacher*, *21*(4)

“ Three themes were identified. Faculty and residents perceive that student experiences on perioperative clerkships are shaped by (1) students' ability to adapt to the specialty and operating room norms on these clerkships, (2) students' understanding of how they can meaningfully contribute to the clinical team, and (3) dedicated teaching time constraints. Interventions were suggested to address educator expectations and student gaps, such as implementing a pre-clerkship orientation across anaesthesia, general surgery and OBGYN”.

“Faculty and residents identified that medical students' experiences are influenced by how they see their role and meaningful contributions within the clinical team. Educators perceived that the role of the medical student within the care team was to prepare for the cases in the OR and to assist the team on the floor with documentation, following up with the patients, and notifying the team of updates, such as new imaging, abnormal labs, or consult recommendations. As such, they expected students to know their patients' medical history and management in detail and to learn to anticipate patient care needs”.

“A recent student who I think really excelled… she picked up patients, and… she was very consistent with seeing that patient every day… [and] knowing the latest information about that patient. (Surgery Attending 1)”.

“In addition, faculty frequently reported that students had positive clerkship experiences when they were proactive in their patients' care and could ‘insert themselves and know what's needed without directly being asked’ (Surgery Resident 2)”.

“I think the most effective med students on surgery are the ones who… have a little bit of an innate idea of where they can fit in. So they're ones that… are not waiting for someone to tell them every step of what they should be doing that day, but recognizing patterns. (Surgery Resident 4)”.

"However, educators in this study were unsure if students were given clear expectations. One resident perceived that the students felt 'a little unsure of their role [within the clinical team] which [was] always kind of true on any new rotation, but particularly true on… surgical services' (OBGYN Resident 1)".

"One resident perceived that the students felt 'a little unsure of their role [within the clinical team].'

"Some residents and faculty also recognised that a lack of orientation and team building, such as failing to introduce students to the staff before the start of a case, contributed to students feeling intimidated and hesitant to take initiative in their learning and their patient's care, leading to a subpar experience in the perioperative clerkship".

"When I have a med student, that med student gets introduced to the team… and that really helps a lot. And when we don't have that same kind of huddle, even without the med student, it makes for a worse day. (Anaesthesia Resident 2)".

Florida Atlantic University
Medical Student Roles and Supervision Policy
Policy Details
Effective Date:
April 10, 2018

Supersedes:
COM Administrative Policies Initially Adopted February 28, 2007; amended June 1, 2009; September 30, 2010; January 19, 2011; June 12, 2012; May 10, 2013; July 10, 2014; Medical Student Roles and Supervision Policy Adopted April 10, 2018.
Responsible Authority:
Senior Associate Dean for Medical Education

Policy Statement

It is the policy of Florida Atlantic University Charles E. Schmidt College of Medicine that medical students must have appropriate clinical supervision while participating in all required and elective clerkships and rotations. In keeping with the statutes of the State of Florida and the requirements and standards of the Liaison Committee on Medical Education [LCME], all medical student trainees will function under the supervision of a faculty member or designee, with such designees including resident physicians (e.g. interns, residents, and fellows) and licensed independent practitioners (e.g., nurse, nurse practitioner, physician assistant, nurse midwife, nurse anesthetists), who are ultimately responsible for that patient's care.

LCME Standard 9.3 (Clinical Supervision of Medical Students) "A medical school ensures that medical students in clinical learning situations involving patient care are appropriately supervised at all times in order to ensure patient and student safety, that the level of responsibility delegated to the student is appropriate to his or her level of training, and that the activities supervised are within the scope of practice of the supervising health professional." [LCME Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Effective July 1, 2018]

PURPOSE:

To provide guidelines and procedures for the supervision of medical students participating in clinical rotations and clerkships with members of the medical staff who hold approved clinical privileges at the College of Medicine and/or its affiliated clinical sites.

SUPERVISION:

Qualified physicians in good standing on the medical staff of the College of Medicine or an FAU approved clinical site and holding an FAU College of Medicine Faculty appointment may serve as clinical supervisors and engage in the teaching, clinical supervision, and evaluation of students.

Medical students are defined as students actively enrolled in the FAU College of Medicine as candidates for the MD degree who are participating in approved clinical rotations and clerkships, as well as students accepted through the Visiting Student Application Service (VSAS) or other approved FAU College of Medicine medical student exchange programs. Medical students participating in away rotations shall be subject to, and must adhere to, the supervision policy of the host institution.

All medical students will be directly responsible to and supervised by designated faculty supervisor(s) with College of Medicine faculty appointments during each clerkship/rotation. Supervising faculty members may, when they deem appropriate, delegate teaching and supervisory responsibilities to designees, including residents, fellows, or licensed independent practitioners who serve as healthcare extenders and are capable of providing the appropriate level of medical student supervision for patient care within the scope of their licensed practice. FAU approved clinical sites are responsible, consistent with applicable regulations and industry standards, for assuring that the healthcare providers employed at their site are appropriately trained, certified, and credentialed.

The supervising faculty member who is responsible for the care of the patient shall determine the appropriate level of student involvement/participation in patient care and the degree of supervision required and should do so within the guidelines of this policy. Medical students are expected to assume developmentally appropriate, graduated levels of responsibility during their training all while being directly and/or indirectly supervised (as appropriate). It is the supervising faculty member's responsibility to determine the appropriate level of involvement/participation by the student and level of supervision that each student should have when providing patient care in a clinical learning environment. The degree of involvement/participation of students when providing patient care will be determined by the supervising faculty member based on a number of factors, including but not limited to:

- the developmental level of the student
- the complexity of the care or procedure
- the potential for adverse effects
- the demonstrated competence, maturity and responsibility of each student
- the consent of the patient to have a student involved in their care

Medical students are also always expected to take responsibility for their actions and be accountable for prioritizing the best interest of the patient. Students must recognize their own limitations and request assistance or decline participation in any aspect of patient care that they do not feel comfortable or competent in. Students should always use their best judgement to discern what is safest and best for the patient without fear of any consequences related to their evaluation, assessment, or advancement.

Levels of Supervision:

Direct: The supervising faculty member or designee is physically present with the medical student and the patient. (Required for all procedures)

Indirect Supervision with Direct Supervision Immediately Available: The supervising faculty member or designee is physically present at the clinical site and is immediately available to provide Direct Supervision. The supervisor may not be engaged in activities which would delay his/her response to a student requiring direct supervision. (Faculty supervisor may consider allowing a student to be involved in history taking, physical exam, data gathering, chart review, data analysis, and counseling under indirect supervision. Some 3rd and 4th year students may progress to be allowed to perform venipuncture and IV placement under indirect supervision with direct supervision immediately available.)

Oversight: The supervising faculty member is available to provide review of encounters and provide feedback after care is delivered. (Faculty supervisor would likely consider this only for experienced 4th year medical students performing history and physical exams.)

MEDICAL STUDENT ROLES:

Medical Students in Years One (1) and Two (2) of the MD Program:

- Must clearly identify and introduce themselves to the patient and all members of the healthcare team as a medical student.
- Must be under the direct, indirect, or oversight supervision, as outlined in this policy, of a physician at all times who is a member of the clinical site's Medical Staff with an FAU faculty appointment. Student supervision may be delegated to a resident, fellow, or a licensed independent practitioner serving as a healthcare extender.
- May participate in history taking, physical exam, data analysis and have access to medical records with Oversight Supervision from the faculty supervisor and with patient consent that the student may be involved in this level of care.
- May observe in surgery with appropriate consent from the patient and surgeon of record.
- May assist in minor procedures always under Direct Supervision when the supervising faculty member agrees that the student has achieved the required level of competence and consent is granted by the patient. (e.g., immunizations, venipuncture and IV placement).

- May not document: progress notes, history and physicals, operative notes, or discharge summaries in the patient's permanent medical record.
- May not write or give verbal orders

Medical Students in Years Three (3) and Four (4) of the MD Program:

- Must clearly identify and introduce themselves to the patient and all members of the healthcare team as a medical student.
- Must be under the direct, indirect, or oversight supervision of a physician at all times who is a member of the facility's medical staff with an FAU faculty appointment. Student supervision may be delegated to a resident, fellow, or a licensed independent practitioner serving as a healthcare extender.
- May participate in care and management of the patient under the direct, indirect, or oversight supervision of the supervising physician or designee depending on the situation as defined above.
- May assist in procedures always under Direct Supervision when the attending physician agrees that the student has achieved the required level of competence and consent is granted by the patient. (See Procedures section of this policy)
- Third-year (M3) students may not call consults to other physicians but may, under the direction of their supervising faculty member, call non-physician consults and schedule appointments.
- Fourth-year (M4) students may under direct supervision call consults to other physicians.
- May not write orders or give verbal orders independently. May "scribe" orders only if the supervising faculty member is present and immediately reviews and countersigns the entry.
- May document in the medical record the following: progress notes, history and physicals, operative notes, discharge summaries provided that all student charting in the medical record is clearly indicated as a Medical Student Note. The supervising faculty member will remain directly responsible for the history and physical, progress notes, discharge summary, operative reports and daily visits, as well as compliance with CMS guidelines for student documentation in the medical record.

PROCEDURES:

1. A procedure is defined as any activity that is invasive to the patient, performed in an operating room, requiring a procedure note, or requiring informed consent of the patient.
2. Except as provided in item 3 below, all medical students must be under Direct Supervision for all procedures by a faculty supervisor for whom that procedure is within his/her scope of practice. The faculty supervisor must determine the extent to which that student is competent to participate in the procedure, and the patient must provide prior consent to the student's involvement in the procedure.
3. Medical students are expected to assume developmentally appropriate, graduated levels of involvement/participation in procedures during their training. Procedures that medical students should be proficient in when completing medical school, defined by the Association of American Medical Colleges (AAMC) Core Entrustable Professional Activities (EPAs) for Entering Residency, include venipuncture and inserting an intravenous line. Third- and fourth-year students may develop competency in these technical skills under direct supervision such that their clinical supervisor may decide to allow a student to perform these minor procedures under Indirect Supervision with Direct Supervision Immediately Available with the consent of the patient. These are the only procedures that may proceed to indirect supervision at the discretion of the supervising faculty member who is ultimately responsible for the care of the patient.
4. As with all clinical encounters, students must ask for assistance as needed if faced with any circumstance beyond their skill level or comfort. It is the professional expectation that each medical student knows the limits of his/her capabilities and requests assistance in the interest of patient safety without regard for his/her assessment or fear of reprisal.
5. It is the supervising faculty member and medical student's responsibility to ensure compliance with this policy. Ultimately, the supervising faculty member shall make the determination of the level of involvement/participation each student should have when providing patient care in a clinical learning environment.
6. Medical student activities may not be billed for except as permitted by CMS regulations. It is the responsibility of the supervising health professional to assure compliance with all local, state and federal guidelines regarding the provision of care, as well as documentation, and billing for services provided by the appropriately licensed and/or credentialed professional.

Dean, School of Medicine and Vice Chancellor of Health Affairs

Job description This is a pivotal moment for the UCSF School of Medicine. Amid evolving healthcare economics, rapid scientific advancement, growing expectations for equity and accountability, and volatility in federal research funding, UCSF seeks a bold, integrative leader capable of sustaining excellence while shaping the future of academic medicine.

Reporting to the Chancellor of UCSF, this role encompasses the dual appointment of Dean of the School of Medicine and Vice Chancellor of Medical Affairs , a position central to advancing UCSF's academic and clinical missions.

As Dean and Vice Chancellor for Medical Affairs , this leader serves as the chief academic and administrative officer of the School of Medicine, responsible for strategic vision, faculty affairs, graduate and undergraduate medical education, research enterprise leadership, and financial stewardship.

The Dean and Vice Chancellor also plays a central role in aligning academic priorities with the clinical enterprise, serving as a key partner to UCSF Health leadership, reporting with the President and CEO of UCSF Health to the Chancellor who serves as Chairman of UCSF Health, and ensuring integration across academic, clinical, and research missions.

The successful candidate will be a visionary academic physician leader with deep experience navigating the complexity of a large, decentralized academic health system. They will be decisive yet collaborative, strategic yet pragmatic, and capable of inspiring confidence across faculty, learners, clinicians, administrators, donors, and external partners.

KEY RESPONSIBILITIES

• Provide visionary, enterprise-wide leadership for the UCSF School of Medicine and UCSF Health, advancing UCSF's position as a leading academic medical institution across research, education, and clinical care.
• Develop and execute a cohesive, forward-looking strategy for the School of Medicine.
• Advance a culture of collaboration and mutual respect across all parts of UCSF.
• Establish and steward an effective governance and leadership structure that enables accountability, alignment, and timely decision-making across academic, clinical, and research enterprises.
• Serve as a principal strategic partner to UCSF Health leadership, ensuring strong alignment and shared accountability across academic, clinical, and research missions.
• Provide overall financial and operational stewardship for the School of Medicine, ensuring fiscal sustainability, strategic investment, and long-term growth.
• Recruit, develop, and retain outstanding academic and administrative leaders, fostering a high-performing, collaborative, and mission-driven culture.
• Advance national and international prominence in research and discovery by strengthening the discovery and translational science continuum, expanding the extramural funding portfolio, and investing in emerging areas of scientific opportunity.
• Provide strategic oversight of School of Medicine departments, campus-wide centers and institutes, ensuring alignment with institutional priorities and maximizing impact.
• Lead the continued evolution of UCSF's innovative medical education programs, promoting educational excellence, equity, and an exceptional student experience.
• Advance a best-in-class clinical enterprise, distinguished by clinical outcomes, destination programs, innovation in care delivery, and clinical scholarship.
• Provide campus-wide leadership for the School of Medicine, working closely with the Chancellor, senior leadership, Deans of the health professional schools, and the academic senate to advance shared priorities.
• Convene and lead the Deans' Council, promoting strategic coherence, collaboration, and communication.
• Champion opportunity for all as core institutional values embedded across education, research, clinical care, and leadership.

• Act as a visible leader in philanthropy, strengthening donor relationships, and securing investment aligned with strategic priorities.

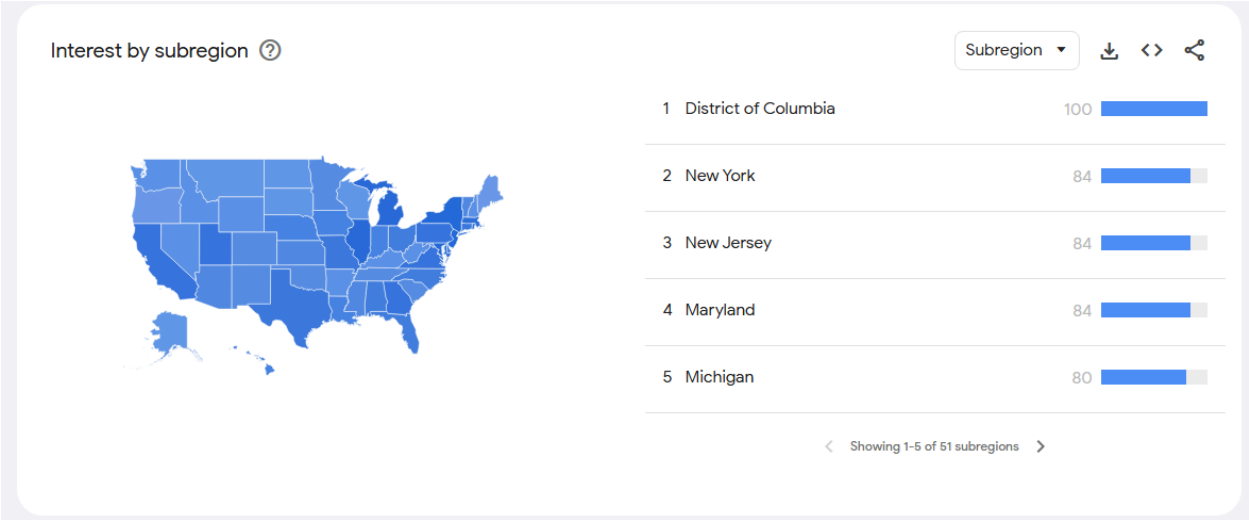
• Serve as a compelling ambassador and national thought leader for UCSF and academic medicine, representing the institution with credibility and influence at the institutional, regional, national, and international levels.

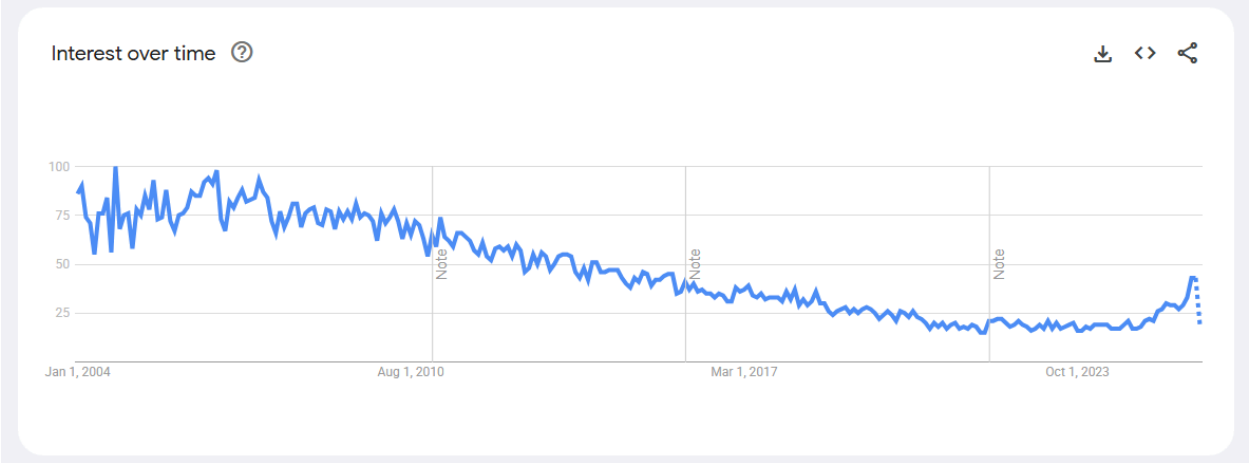
An offer will take into consideration the experience of the final candidate AND the current salary level of individuals working at the University of California in potentially similar roles. The anticipated range for this role is $1M to 1.4M total cash compensation. The final salary and offer components are subject to additional approvals based on UC policy.

Lee A, Hoyle E. Who would become a successful Dean of Faculty of Medicine: academic or clinician or administrator? Med Teach. 2002 Nov;24(6):637-41

It has been a long tradition that the medical school dean is an expert in a specialist field with a well-established reputation in research and clinical services. Medical education is no longer simply disease orientated; it is required to put an emphasis on prevention, the need for better management of the health care system, and the need for a better understanding of the sociopolitical aspects of medical care. The deans of medical schools must appreciate the social role of medical education, and the social contract with the community. Although doctors might have difficulties with leadership because they are trained to work as individuals and to value highly their independence and autonomy, good communication skills are an asset for clinicians in management roles. It does not matter whether the background of the dean is academic, clinical or administrative; the most important thing is to possess the managerial skills to tackle the three-way tension between management, academic leadership and professional leadership. The job should be open to people with a good knowledge of and background in health and fiscal expertise, and also a high degree of management, diplomatic and interpersonal skills. Those skills should also be emphasized in the medical curriculum.

"Top medical schools"





MS4 Requires for West Virginia University

MS4 Requirements | School of Medicine | West Virginia University

Procedure for Scheduling

In consultation with a faculty advisor and using the forms and instructions provided by Student Services in Morgantown, Charleston, or Eastern, each third year student develops a proposed fourth year schedule. The importance of early consultation with the appropriate faculty advisor cannot be overemphasized.

Students must satisfactorily complete eight and one half (8.5) blocks (34 weeks) of academic rotations (2 weeks of this time may be used as USMLE Step 2 CK study time). No release/interview time may be taken or scheduled during required rotations.

Performance Evaluation

Student performance is evaluated by elective preceptors through evaluations sent through eValue. Grading designations are Pass - Exceeds Expectations, Pass, Fail and Incomplete. Students are expected to evaluate the quality of the electives offered, providing feedback on evaluations sent through eValue throughout the year.

Family Medicine Subinternship
LOCATION: Charleston Area Medical Center, Charleston, West Virginia
PRECEPTOR: Courtney Beasley, MD and Kathleen Bors, MD
DURATION: 4 weeks
OFFERED: Continuously
MAXIMUM ENROLLMENT: 2 Students
STATUS: This rotation fulfills the senior requirement for a Sub internship.

Objectives

To introduce students to principles of diagnosis and treatment of problems encountered in family practice in a hospital-based setting. To introduce the student to a variety of patient care settings encountered in family medicine.

Methods to Achieve Objectives

Each sub intern functions under the supervision of a resident and attending physician. The sub intern is responsible for clinical evaluation of patients admitted to the Family Practice Inpatient Service. Duties include obtaining initial history and performing physical examination of the patient, writing orders, daily follow up of hospitalized patients, writing H&P's and daily progress notes, patient education, performing diagnostic procedures, and communicating with consultants as well as patient families. The sub intern is an integral part of the team who participates fully in patient care. The sub intern is also expected to follow up patients in the office after discharge. In addition, the sub intern may be required to make informal presentations on pertinent inpatient topics. Sub interns will take call 6-7 times per month. Formal didactic inpatient teaching rounds are held each morning in addition to bedside teaching.

M.S. in Healthcare Administration and Medical School Leadership Essay Questions

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Medical School Leadership

Admissions & Diversity

1. Analyze how the admissions policies at **Harvard Medical School** have evolved to address racial and socioeconomic disparities.
2. Should **Johns Hopkins School of Medicine** continue to use legacy preferences in admissions? Discuss with reference to equity in higher education.
3. Evaluate the effectiveness of pipeline programs like **BRIDGE Program at Duke University School of Medicine** in increasing underrepresented minorities in medicine.
4. How should **University of California, Los Angeles David Geffen School of Medicine** adjust interview practices to mitigate bias against first-generation college applicants?
5. Examine the challenges of admitting students with interrupted medical training due to the COVID-19 pandemic and suggest policy reforms.

Curriculum & Societal Challenges

6. How should **University of Michigan Medical School** incorporate structural racism and health equity into its core curriculum?
7. Propose curricular changes for **Columbia University Vagelos College of Physicians and Surgeons** to prepare students to address the U.S. opioid epidemic.
8. Assess the responsibility of **University of Washington School of Medicine** to include climate change and planetary health in medical training.
9. Debate whether schools like **Mayo Clinic Alix School of Medicine** should mandate instruction on LGBTQ+ health disparities.
10. Design an elective for **Perelman School of Medicine at the University of Pennsylvania** that addresses vaccine hesitancy in underserved urban communities.

Faculty, Culture & Institutional Policy

11. What concrete actions should **Stanford University School of Medicine** take to retain Black and Indigenous faculty in competitive academic departments?
12. Propose mechanisms by which **Yale School of Medicine** can reduce faculty burnout while maintaining high research productivity.

13. Critique the tenure system at major research schools and its impact on clinical teaching quality.
14. How can **University of California, San Francisco School of Medicine** strengthen support for trainees reporting harassment or discrimination?
15. Should schools like **Baylor College of Medicine** adopt transparent salary bands for faculty to reduce pay inequities? Why or why not?

Ethics, Public Health & Partnerships

16. Analyze the ethical risks and benefits of **University of Pittsburgh School of Medicine** partnering with pharmaceutical companies on research.
17. Discuss how **Michigan State University College of Human Medicine** should respond administratively to student concerns about participating in experimental gene-editing research.
18. Evaluate the role of medical schools in advocating for universal health coverage in the U.S.
19. How should institutions like **University of Colorado School of Medicine** ethically allocate scarce clinical training slots in rural rotations?
20. Debate whether medical schools have an obligation to publicly oppose discriminatory state healthcare policies.

Leadership, Strategy & Accreditation

21. Propose a strategic plan for **Case Western Reserve University School of Medicine** to improve outcomes on the USMLE Step exams without narrowing clinical reasoning skills.
22. Examine how **Icahn School of Medicine at Mount Sinai** can use its community partnerships to reduce local health disparities in East Harlem.
23. Assess the impact of **University of Texas Southwestern Medical School** meeting new LCME accreditation standards on student wellness programming.
24. How should leadership at **Weill Cornell Medicine** balance pressures for research revenue with community service missions?
25. Critically evaluate the role of a medical school dean in leading institutional responses to national crises such as pandemics or civil unrest.

Hospital Leadership and Strategy

1. Discuss the qualities that make an effective hospital CEO and how they influence hospital culture.

2. How should hospital leaders balance financial sustainability with patient care quality?

3. Examine the role of a hospital administrator in implementing strategic plans during a healthcare crisis.

4. What strategies can hospital leaders use to foster innovation while minimizing operational risk?

5. Evaluate the importance of transparent communication between hospital leadership and staff.

Operations and Management

6. How can hospital leaders improve patient flow and reduce wait times without compromising care quality?

7. Discuss the challenges of managing multi-specialty hospitals versus single-specialty hospitals.

8. Evaluate the role of hospital leadership in supply chain management, particularly during shortages.

9. How should a hospital director prioritize resource allocation during a public health emergency?

10. Discuss strategies for integrating technology and electronic health records to improve hospital efficiency.

Financial Management

11. How can hospital administrators balance cost containment with the need to invest in staff and infrastructure?

12. Discuss the ethical challenges of billing practices and revenue generation in hospitals.

13. Evaluate the role of philanthropy and donations in hospital operations and strategic planning.

14. How should hospital leadership respond to changes in healthcare reimbursement models?

15. Analyze the financial implications of implementing cutting-edge medical technologies in hospitals.

Human Resources and Staff Management

16. Discuss effective strategies for reducing physician and nurse burnout.

17. How should hospital leaders address conflicts between clinical staff and administrative staff?

18. Evaluate the role of mentorship and professional development programs in hospital leadership.

19. Discuss approaches to promoting diversity, equity, and inclusion among hospital staff.

20. How can hospital leaders encourage a culture of safety and accountability?

Ethics, Policy, and Public Health

21. What ethical considerations must hospital leaders weigh when allocating scarce resources, such as ICU beds?

22. How should hospitals respond to community health crises, such as epidemics or natural disasters?

23. Discuss the role of hospital leadership in advocating for public health policies.

24. Evaluate the challenges of balancing patient privacy with data-sharing initiatives for research and public health.

25. How should hospital administrators manage partnerships with pharmaceutical companies or medical device manufacturers to avoid conflicts of interest?